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INTERVIEW WITH DR. GHASSAN ABU SITTA

"There Is No International Community"

PERLA ISSA

Since 30 March 2018, Palestinians in the Gaza Strip have been holding weekly Friday demonstrations along the 1949 armistice line between Gaza and Israel. Called by its organizers the Great March of Return, the protest is focused on the right of return of Palestinian refugees and their descendants to their ancestral homes in what is now Israel. Additionally, demonstrators are protesting the illegal eleven-year air, sea, and land blockade imposed by Israel and supported by Egypt.

Gaza is home to almost 2,000,000 Palestinians, two-thirds of them refugees. Population density is one of the highest in the world and nearly half the population was under fourteen years of age in 2015. The blockade, in force since 2007, has worsened what were already dire living conditions. In 2017, the World Bank placed youth unemployment in Gaza at 60 percent, with growth in real gross domestic product (GDP) dropping to 0.7 percent as a result of the hollowing out of the productive base by the decade-long blockade.†*

It is in this context that the weekly Friday demonstrations began on 30 March 2018 after Gaza-based journalist and activist Ahmed Abu Artema wondered in a Facebook post "what would happen if 200,000 protesters gathered near the Israel fence with Gaza Strip, and entered the lands that are [theirs]."‡ Tens of thousands of people answered the call, and eventually the Great March of Return movement, established by Abu Artema and an organizing committee composed of fellow activists, received the official blessing of all major Palestinian political factions. The launch date for the protest marked Land Day, the annual commemoration of 6 Palestinian citizens of Israel killed by Israeli police and army troops on 30 March 1976 as they protested Israeli land confiscations in the Galilee. While the Great March of Return was supposed to culminate on 15 May (when Palestinians commemorate the

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* Sara Roy, *The Gaza Strip: The Political Economy of De-development*, 3rd ed. (Washington, DC: Institute for Palestine Studies, 2016), p. 13.

† World Bank, *Economic Monitoring Report to the Ad Hoc Liaison Committee* (18 September 2017), http://documents.worldbank.org/curated/en/515891504884716866/pdf/119657-WP-PUBLIC-on-Monday-1-PM-sept-11-AHLC-report-September-8.pdf, pp. 5–6.

‡ Mustafa Abu Sneineh, "Interview: The Palestinian Who Sparked March of Return with a Facebook Post," Middle East Eye, 8 June 2018, http://www.middleeasteye.net/news/Gaza-great-march-return-Israel-Ahmed-Abu-Artema.

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Nakba, the mass expulsion that preceded and followed the declaration of the State of Israel in 1948), the protests have continued to this day. Tents have been erected at five locations along Gaza's eastern boundary, where the Israeli military meet the now weekly Friday protests with deadly fire as well some kind of nerve gas. As the Journal *went to press, Israeli snipers had killed upward of 190 Palestinians from Gaza, many of them children, as well as emergency medical personnel, and local journalists; they had injured and maimed an estimated 18,000 unarmed protesters.*

On 7 June 2018, the Journal of Palestine Studies *had the opportunity to speak to Dr. Ghassan Abu Sitta, the head of plastic and reconstructive surgery at the American University of Beirut (AUB) Medical Center, about ten days after his return from volunteering in Gaza for two weeks in May. Abu Sitta is a veteran of battlefield medicine: he worked as a medical volunteer in Iraq during the Gulf War (1990–91); in Palestine during the First and Second Intifadas (1987–93 and 2001–5); in South Lebanon during Israel's so-called Operation Grapes of Wrath (1996), and in Gaza during the Israeli attacks of 2008–9, 2012, and 2014. He is also one of the founders and the codirector of the Conflict Medicine Program (CMP) at AUB's Global Health Institute.*

Dr. Abu Sitta arrived in Gaza three days ahead of the 14–15 May demonstrations that were expected to be the culmination of the six-week Great March of Return, coinciding with the annual commemoration of the Nakba as well as the relocation of the U.S. embassy in Israel from Tel Aviv to Jerusalem. He spoke to the Journal *about the medical preparations ahead of the protests, the unfolding of events on 14–15 May, the types of injuries he witnessed and treated, the kind of ammunition being used by the Israeli army, the state of the health sector in Gaza, and last but not least, he underlined the inaction of the international community, including that of the Arab countries.*

Please start by telling us generally about your recent two-week experience in Gaza.

I got to Gaza on the eleventh, a Friday. I arrived very early and I put my bags at my in-laws' as I was going to be able to stay with them this time given that the violence was confined to the boundary fence, and movement elsewhere was fine. (I had not been able to stay with them on prior occasions because movement was dangerous during major Israeli assaults on Gaza.) I went to the hospital on the same day and started taking inventory of the equipment to try to figure out what was missing for the kinds of injuries that were occurring, which were overwhelmingly limb injuries.

I was based at al-Awda Hospital, a place with which I go back a long way. I worked with the Union of Health Committees during the First Intifada when they were just being formed. And then during the Second Intifada, I took six months off from my job also to work at al-Awda, and again during the 2012 attack on Gaza. During the 2008 and 2014 wars, I was at al-Shifa Hospital. I wanted to be based at al-Awda this time in particular because the hospital is very close to Bayt Lahiya, one of the major flashpoints along the fence in the north; al-Awda is also close enough to Bayt Hanun, which is a secondary flashpoint, also in the north.

As I watched the [weekly] Friday demonstrations progressing [from Beirut where I live], I knew that the fourteenth and fifteenth of May would be major and that people were going to attempt to cross the armistice lines into '48 [Israeli territory]. From what I could see of the injuries up until

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then, all required reconstructive surgery. So, I made the conscious decision to try to get to Gaza as early as I could before the fourteenth and give myself a few days to figure out what was missing that I might need.

On that first Friday I was there, cases started streaming in after Friday prayers, and two of them needed really major surgery. I operated on them that afternoon, and started sending out messages to all of the NGOs and charities that I know to try to get more funding and equipment.

Then, on the Saturday and the Sunday that followed [12–13 May], we worked on some cases and I saw several from the 2014 war that needed further work, particularly kids. When kids are injured, reconstruction doesn't stop, because they keep growing, and therefore they have continuous surgical needs. As I started seeing current injury cases, I was then given a waiting list of 500 injured patients who needed reconstructive surgery from the previous four Fridays of demonstrations.

I therefore started to put together a work plan with the local team but the decision was taken to process these cases *after* the fourteenth because we knew that was going to be a big day. By this time, a team from Médecins Sans Frontières (MSF)–Belgium had joined us and we drew up a contingency plan for the fourteenth with them. We set up a tent in the parking lot to keep the gas inhalation cases out of the hospital building so that the gunshot wounds could get in, and we turned one of the auditoriums into a minor surgery theater for the injured who needed cleaning and suturing under local anesthetic. We moved the chairs from the reception area so that it could become another ward for inpatients as the hospital had only 70 beds and we knew that we were going to have more than that many admissions.

On Monday the fourteenth around 4:00 P.M., we got the first injury. A guy, shot in the abdomen, who couldn't be stabilized in the emergency room, and was therefore taken immediately to the operating room, where we found he had five perforations to the bowels. Only one bullet had pierced his abdomen but it had made five holes, which is why he was bleeding so much. Then slowly more injuries started to arrive. Initially one per ambulance and then soon enough, the ambulances were bringing in five or six at a time. The emergency room was completely full, as were all of the operating theaters, all of the minor surgery areas, and every other space.

My job as a senior surgeon in the emergency room was to go from bed to bed to make the decision: this injury needs to go straight to the operating room, this injury needs to go to the ward and wait for surgery, or this injury needs to be seen, treated, and sent home and then brought back for follow-up. The idea being that you are trying to preserve as much of the hospital's capacity as possible and to keep one operating room always available for a case that can't wait, like the guy with the perforated bowels.

The World Health Organization (WHO) had worked in tandem with the Ministry of Health to create a trauma cluster, which included the ministry itself, the Gaza Red Crescent Society, as well as NGOs; they had reorganized the trauma pathway, as we call it, in such a manner as to ensure that all of the injuries went to what are known as "stabilization points" along the boundary area, one to two hundred yards from the so-called "fence." These are essentially field hospitals where patients can be stabilized, have an IV inserted, and bleeding can be stopped using a tourniquet. And they would get splints for their fractures. The other part of the plan was to send medical teams to the peripheral hospitals so that al-Shifa [Gaza's largest hospital] would not be completely overwhelmed by the first wave. The patients would then leave the stabilization points, while the team there contacted

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the [destination] hospital. The emergency medics knew ahead of time which hospital had what kind of surgery: so for example, at al-Awda, we had a vascular surgeon, a plastic surgeon, and an orthopedic surgeon while Shuhada' al-Aqsa Hospital, in Dayr al-Balah, in the center of the territory, did not have a vascular surgeon; in short, patients would be directed to the hospital with known capacity for their injury.

By 7:00 P.M., the system was on the verge of collapse. There were more injuries than there were beds, or operating rooms, in all of Gaza. Patients at al-Shifa were waiting four to five hours to get into the operating theater. At al-Awda alone, we had seen 120 gunshot wounds, and we were only a 3-operating room, 70-bed hospital. Every single case needed some kind of surgical intervention. And then suddenly there was a decision by the organizing committee of the march, I believe, to start pulling people back because they realized the system was basically about to collapse. By 7:00 P.M. it had become apparent that over a four-hour period, the number of injured had reached 3,500, with around 1,500–2,000 of those being gunshot wounds.

Other than the 120 gunshot wounds at al-Awda, we had a lot of gas inhalation cases. And this wasn't tear gas but *nerve* gas. These cases have continuous convulsions for an hour and need close monitoring and intervention in the form of anticonvulsants. We started processing those who needed surgery around 7:00 P.M. so as to try to get all the surgeries out of the way before the next day dawned. We were worried about what would happen the following day. That night, we operated on 25 cases, I did 9 of the total and the rest were done by the general surgeon or the vascular surgeon. There were lots of cases done under local anesthetic in the makeshift operating room that we had set up. By midnight or so, we were done: we had gone through everybody, those who could be sent home were sent home, and those who needed to stay were able to do so.

The following day, the number of injured actually dropped because the whole of Gaza was in a state of shock: there had been 63 killed, 44 amputations, and 3,500 wounded in the space of four hours the day before . . . meaning that we were looking at something closer to a World War I–type carnage than a demonstration. The drop in casualty numbers allowed us to take on more cases: by day three, we were beginning to look at reconstruction for the previously injured and to really start to figure out what we would need for them. And the initial waiting list of 500 I mentioned earlier had more than tripled: there were now 1,600 cases that needed reconstructive surgery, that is, *repeated surgical interventions* were required to reconstruct these injuries.

MSF-France set up 4 community-based dressing clinics where the wounded who were being discharged early from the hospitals to make space for others were being seen. These community-based clinics therefore had a good overview of the kinds of injuries being caused and a good database of who needed what.

At al-Awda, we started working with MSF-France and MSF-Belgium to try to see how to proceed and what cases to prioritize from among the 1,600. And that was it. We started doing around 4 to 5 cases a day, and then a couple of days later, I got a call from al-Ahli Hospital, which is the oldest in Gaza (built in 1880, and formerly known as the Baptist Hospital), saying they didn't have a plastic surgeon, they had wards full of people, and could I start coming over to operate? So the way it worked out was that I would go there in the morning, do 5 or 6 cases, and then go to al-Awda in the afternoon and do another 4 to 5 cases there.

By the end of it, that is by the time I came back to Lebanon, I had operated on 68 cases.

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Did the 1,600 cases all get the treatment they needed?

Some of them, around 500 or so, are what we call "compound tibia fractures," that is, the bone of the leg is shattered, the soft tissue is shattered, the nerves and the vessels are shattered. Such fractures need 5 to 7 surgeries. So, there is a subgroup that is going to need a lot of surgical intervention over a two-year period.

Is there the necessary infrastructure in Gaza to do that?

During the first six weeks of the demonstrations [30 March–15 May], the Ministry of Health was not able to provide any other kind of care . . . for the cancers and other kinds of medical cases; there were no beds for them, and no operating space for them. The system was completely overwhelmed, running at three to four times its capacity.

The demonstrations continued to take place every Friday, and we would get between 20 and 30 injured every Friday, adding to the list. We just kept going. MSF-Belgium decided to basically keep their team at al-Awda for the foreseeable future in order to help take care of the wounded and to support the hospital in setting up a program of treatment for these injuries.

Can you give us examples of specific cases?

There were lots of cases of what we call "fragmentation bullets," historically known as "dumdum" bullets. Fragmentation bullets were the first weapons to be banned in international law because the very point of that particular weapon is to maximize injury: a fragmentation bullet fragments into 20–25 different pieces when it hits the body. We saw lots of those.

A guy came in one day with two bullet wounds, one in each of his ankles. From the trajectory of the bullet, we could tell that this was not a "through-and-through," that is, when a bullet penetrates one limb, exits, and then goes into another limb. These were two separate bullets, and the fact that they were both lodged in his ankles meant that they were fired at the same time or else he would have fallen. This man was shot at the same time by two different snipers.

So, it is very likely that the two snipers were coordinating with each other to target this man, that it was not an accident. They must have been talking and saying let's shoot this guy, I'll take the right ankle and you take the left. That is what this injury implies.

Yes absolutely, it was not an accident. It's like a game, a sport.

You spoke a little bit about the types of ammunition used. Can you expand on that?

Tissue damage is all about the transfer of energy from the bullet to the tissue. So by definition, by their very nature, "regular" sniper bullets have the highest form of energy and therefore the amount of damage that they are capable of causing is immense. But what we saw is that even these bullets were being tampered with by the snipers to allow them to behave like fragmentation bullets so that they would release more energy as they hit the body. They were drilling the bullets in such a way as to weaken the tips, so that once a bullet hit the body it would fragment into multiple pieces.

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That's a lot of work.

It is work, really. And that is the other issue. There is a level of intimacy in sniper injuries that doesn't exist in other acts of war. For example, a fighter pilot travelling at 15,000 feet in the air will not see their victims' faces, nor will an artillery gunner. But the sniper sees your face, he sees your expressions, he sees your age, he sees where he wants the bullet to lodge, he knows exactly what kind of damage his bullet will cause to that location. So, it's an intimate crime when you see the face of your victim—it's a much crueler crime—and I think it is the expression of a level of dehumanization and racism now so ingrained in the average Israeli as to allow that kind of crime to take place.

Was there a pattern to the gunshot wounds?

They were mostly to the limbs. From the kind of ammunition used and the body areas that were targeted, the aim was to maim, to produce the kinds of injuries that would both incapacitate the health system and turn the able bodies of these young men into burdens on their families. Because at the end of the day, these young men were most likely going to end up being manual laborers, and now they are incapable of doing that. The majority of them will end up with some form of disability.

How do you explain the extremely high number of injuries?

The Israelis understand that the world counts the dead and considers the injured or the wounded a lesser crime, so to speak, and so it is an attempt at creating an "iceberg effect": that is, a situation *where what is apparent is the killed* but *the real crime is in the wounded* [who are not as visible] and the type of wounds that have been inflicted. To have 13,000 wounded in a place that counts 1.8 million people . . . that figure bespeaks a battlefield, not a demonstration.

What was the age group of those killed and injured?

I would say 80 percent of them are between the ages of fifteen and twenty-five. The majority are male and around 20 percent are female.

Can you tell us more about the situation in Gaza itself, what it's like there?

What you notice most is the level of poverty. The economic situation is horrifying, starting with the medical staff who have not been paid for a year and a half because the Palestinian Authority has simply stopped disbursing their salaries. Then you see the patients, the kids, who exhibit stunted growth, meaning that their weight and height are well below the norm for their age. Add to that the fact that all of the wounded, when you do their intake forms before admitting them, are unemployed. And that the night before the start of Ramadan, on my way back from the hospital to where I was staying, I drove through the Jabaliya market, it's a populous area, usually thronging with wooden produce carts, and it was empty . . . you know how the night before Ramadan people usually go on a frenzy to shop for the rest of the month. That night, I also went to Omar al-Mukhtar Street, Gaza's main commercial thoroughfare [where] the old shops [are located]. That was also empty. There is zero money in the system.

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And what about the state of the health system?

Before the beginning of the demonstrations, the Ministry of Health was running at 40 percent capacity of essential drugs. The WHO has a list of medications that is the basic minimum to run any medical system, and Gaza only had 40 percent of the essential drugs required.[§] But also, it was apparent from the equipment that I was using that some of it had been around since I had worked there in the Second Intifada [over thirteen years earlier]. Old, well beyond its shelf life, a lot of it broken, a lot of it needing replacement, a lot of pieces of equipment missing. For example, when we put in external fixators we normally use a medical drill that we sterilize, but that was broken, so we were using a regular wood drill.

Imagine being in a system that hasn't been able to renew its equipment in over twelve years, despite continuous use and three wars. Imagine a system where the majority of the doctors spend their time watching conferences and courses pass them by, not because they are not invited but because they can never get a permit to leave. Imagine a system that is unable to deal with day-to-day problems because it has to deal with these wars cyclically. There are already 22,000 war-related disabilities in Gaza as a result of those. All of these people have had surgeries, and all of them have added a burden on the system, not to mention the remainder of the injured (who have not been disabled) and all the fatalities. It is a system that is just running on the dedication of its staff, and little else.

You carried out 68 operations: Can you provide examples of things lacking in the operating room?

When you operate on a limb you need something called a tourniquet. It is an inflatable cuff that stops the bleeding. As there weren't any, we had to use rubber bands. Also, there was no drill. The forceps and the scissors were so far gone beyond their shelf life that they would snap or not work. The skin graft knife was in a miserable state: it was a 1950s knife, which is mechanical (operated by hand) rather than what is used currently, which is a motorized knife.

Have there been any successful attempts to bring in new medical equipment since you were there?

There have, but they come nowhere near to meeting the needs. Gaza is still a prison, even if you increase the food rations: that's the analogy. Unless you lift the siege, you will never be able to run a health system that responds to people's needs.

You mentioned growth stunting. Can you tell us more about what you noticed?

It was obvious. Stunted growth is a recognized measure for pinpointing the effect of chronic malnutrition on children; it is based on the height-to-weight ratio, and there is an international standard created by the WHO for these ratios. We know now (there was a big article about this in the journal *Nature* recently) that even the brain stops growing properly in children with stunted growth. It was obvious. When you need to give a child a general anesthetic, to put them to sleep, you need to know what their weight is; in a war situation, you don't have time to weigh them, you have to guess their weight from their age. But you can't accurately guess their weight when they look three or four years younger than their age.

[§] See Photos from the Quarter, *JPS* 47 (1).

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What are your expectations for tomorrow [Friday, 8 June 2018]?

I think tomorrow is going to be a very rough day. I got a message from the director of al-Awda yesterday saying that they are expecting it to be a medical emergency. They are dealing with it as another potential May 14th.

You see, on the one hand, people in Gaza don't want this senseless butchery, but on the other, they have been left with no other choice.

Many people say that Gaza is on the verge of imploding or collapsing. Would you say that the process has already started?

When does an implosion happen? When 95 percent of the water is undrinkable? When electricity is on three hours a day? When the International Labor Organization (ILO) says that this is the highest unemployment rate in the whole world, greater than in sub-Saharan Africa, higher than any other place? Today, 66 percent of the workforce is unemployed according to the ILO. What is it that we need to see in order to say that there *is* a collapse?

What impressions did you come away with after leaving Gaza?

There are multiple levels to this. On a very basic level, people will not tolerate another twelve years of siege. So this is the social driver. And on the political level, you realize that this is the end of a phase. The ten-point program unveiled by the Palestine Liberation Organization (PLO) in 1974, which eventually led us to Oslo, is gone. And with it the two-state solution. What will come after it, nobody knows. But that moment has ended.

It is obvious that this is a societal change, these [demonstrations] are not being driven by anybody in politics. The political parties and factions are following the street. There is a specific age group and a specific agenda . . . they may not have had the time yet to articulate that agenda properly or to create a hierarchical structure of leadership, but it is obvious that this is a phase, not just an event. So the end of the PLO, and its elites in all their forms, leaves us at a juncture where these young people are trying to take the struggle somewhere else. Where to, nobody knows. The inability of the West Bank to respond in a meaningful way to what is happening in Gaza is a major obstacle. A major boost is that a similarly aged group to the one in Gaza is now mobilizing inside Israel. But this is certainly not the end of it.

The ending to this transitional phase is not clear. Obviously, the era of the factions is coming to an end: they will, all of them put together, become "a" player but will no longer be "the" player. On the Israeli side, and this is the irony, we are also witnessing the end of the political elite that created and has led the state since it was established. The fact that [Israeli prime minister] Netanyahu is facing the kind of legal challenges before him now means that the Israeli establishment is no longer worried about replacing him—that there are replacements for him. Those calling for "transfer" [the wholesale expulsion of Palestinians from Israeli-controlled territory], and those political parties whose ideology is based on the notion of transfer, are now the mainstream, and no longer the fringe as they were in the 1980s and the 1990s.

How quickly this phase comes to an end and in what direction it goes are dependent on many factors: one is the West Bank, and another is the potential for a regional war. I think the Israelis

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will get to the point where they would rather have a war with Gaza than allow these demonstrations to carry on, because the longer the protests continue, the greater their potential for mobilizing among Palestinians and changing the dynamic within Palestinian society itself. The cause for concern on the Israeli side is that these mobilizing events, these demonstrations, might yield something far worse (for Israel) than what is currently there, whether in terms of leadership or in terms of reshaping Palestinian society.

How different did you find the situation in Gaza compared to the last time you were there?

The behavior of the Ministry of Health was different and I think that is partly a reflection of the change in the leadership of Hamas, with the people like Yahya Sinwar and Ruhi Mushtaha. These men belong more to the First Intifada and to the prisoners' movement than they do to the Muslim Brotherhood and Mujama'a al-Islami. They emerged from a culture where the value of coalition building is appreciated and they privilege that over the "go-it-alone" tendency typical of previous Hamas—and Ministry of Health—initiatives. During the 2014 war, the Ministry of Health was convinced that it could treat the injured by itself and that it didn't have to work with al-Awda, al-Ahli, or anyone else. This "opening up" is in my opinion based on a different understanding that puts Hamas's new leadership closer to that of a national movement than of an Islamic movement. I think this dynamic will be an interesting one to watch.

What do you think of the international community's response?

There is no international community. In 2014, the number of foreign surgeons, myself included, that the Israelis allowed into Gaza was 3. This time around they allowed every team that applied to enter, an indication of how confident and comfortable they feel in the West Bank. Traveling from the [Allenby] Bridge to Gaza I did not feel that sense of tension that was there when I made the same trip in 2014. So, the international community [as a figurative watchdog] is not there. The Arab world has ceased to exist in any meaningful way. Syria and Iraq are swimming in their own blood; Egypt is adamantly refusing, or maybe unable, to play any kind of regional role. The Gulf states have decided to sideline the Palestinian question and to seek direct relations with the Israelis . . . and that's all there is to it.

One of my questions was actually about how you were able to get to Gaza and why would Israel allow foreign surgeons to enter?

Because of that sense of Israel's confidence that I just mentioned. In 2014, the Israelis held me at Allenby Bridge [one of the overland crossing points with Jordan] for twelve hours; this time I was processed immediately, and the same was true at the Erez crossing.

Who applies for your permits?

WHO. They apply for the permits of all the medical teams. They learned from the 2008 war that there needs to be a verification of qualifications. Well-meaning medical teams with no experience of these kinds of injuries can cause more harm than good. So, based on need and qualifications, the WHO will intervene.

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You mentioned that you like working at al-Awda Hospital. Why is that?

I think I like it there because for me, it is where I've worked the longest as a volunteer. I have friends there. There is almost a kind of nostalgia involved: deep bonds that go back a long way.

You also seem to have a special relationship with Gaza. You mentioned that your wife's family was from there. Can you elaborate?

We are from Beersheba, and in 1948 we fled to Khan Yunis. My father, who was a pediatrician, belonged to the generation that emigrated to the Gulf in the early 1950s. My uncle Abdallah, who is the oldest brother, was one of the leaders of the 1936 rebellion, and one of the first to organize the fedayeen between 1948 and 1952. The next brother, Ibrahim, was one of the founders of the PLO, and sat on the Executive Committee alongside Ahmad Shuqeiri. Hamid, another brother, was on the Executive Committee during the time of Abu Ammar [Yasir Arafat]. And then there is Salman, the [famous] historian and youngest of all the brothers. So, although I was born in Kuwait and didn't set eyes on Gaza until 1979, it was always there. Gaza was present my whole life.

Why did you go to Gaza in 1979?

My father just wanted us to see it. Luckily, at the time, travelling between the West Bank, Gaza, and Israel was possible. We travelled the entire coast, all the way from Naqura to Tiberias, to the West Bank and finally to Ma'an Abu Sitta which is the hamlet that the family is from.

You mentioned that your wife is also from there.

Yes, Dima is from Gaza.

Was it on purpose?

Everything in life is on purpose, whether consciously or subconsciously.

How was it staying with her parents?

I had not been able to stay with them on the previous occasions I was in Gaza. In 2014, I could barely make it safely to al-Shifa and back, as even the hospital was being hit. Dima's parents live very close to the barbed-wire fence; you can see the sniper tower from their home. For me, it was important to be able to spend time with them because this trip was a different type of engagement.

How do you feel after all these trips and everything that you've seen? My basic question is, How do you remain sane?

The difficulty is when you try to get back to what is called normal life and the sense of guilt and the sense of abandonment that haunt you, the feeling that you left all of these people behind and that you should be there with them. You are glued to the TV every Friday thinking about when you are going to be able to go back and trying to juggle that with a full-time job, responsibilities, children, exams, and school. You know all of these things become a serious source of stress because you are trying to do the right thing. Now what helps is being with someone who completely identifies with what you want to achieve. That for me has always been the critical part of my relationship

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with Dima. Actually, there was no war or occasion when there was a discussion that I shouldn't be doing this.

You have three boys?

Yes, the youngest is seven and the eldest is fourteen.

And they know what you do?

Yes, they understand, although they don't always verbalize it. During the 2014 war, Dima tried to talk to our middle son, asking him: "Do you know why your dad is going? He is going to treat people." He told her: "You mean instead of fighting?" [*laughter*]

So, he didn't think very highly of what I do [*more laughter*]. He considers it the "sissy" option. But yes, eventually, they come out with it—what they think or don't think.

I am sure they must worry about you.

They are a bit too young to realize the potential consequences of what I do. The one who is fourteen years old, maybe he gets it, but the younger ones don't really realize what could go wrong. But you know in 2006, I didn't come to Lebanon during the war [when Israel bombed Lebanon for thirty-four days during its so-called second Lebanon war] because my son, Suleiman, was newly born and I still hadn't processed what that meant in my own mind, in terms of what I wanted to do. By the time 2008 came around, I had figured out that you actually need to be true to yourself if you are ever going to be a decent parent.

In 2011 there was a protest at the border here in Lebanon. Were you part of the medical team then? And if so, did you find any similarities?

I was in Lebanon at the time, and I treated some of the wounded here at AUB. There were certainly similarities with the bullets. We think that the bullet that hit Munib al-Masri [one of the protesters] was a dumdum bullet.

You are one of the founders of the CMP at AUB. Can you tell us a little bit more about it?

The CMP came out of the fact that, in addition to what we see in Gaza, at AUB we see patients from Syria and Iraq all the time. War wounds are now an endemic disease in the Arab world. When you think that there are 2,000,000 Syrians wounded, and that the Iraqi wounded by far surpasses the number of Syrians wounded . . . and Libya—God knows what is happening in Libya. So, as these kinds of cases end up at the AUB, it means that war wounds are now part of the region's disease load. As an educational institution, first, you need to understand it, and, second, you need to allow the knowledge that you are generating to be reflected in the educational process, that is, in what you teach your own students and what you try to teach practitioners around the region. That's why the CMP, which is part of the Global Health Institute, was set up.

What will you do tomorrow?

I have surgery all day.

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